

## PEER REVIEW HISTORY

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### ARTICLE DETAILS

<b>TITLE (PROVISIONAL)</b>	Role of relatives of ethnic minority patients in patient safety in hospital care: a qualitative study
<b>AUTHORS</b>	van Rosse, Floor; Suurmond, Jeanine; Wagner, Cordula; de Bruijne, Martine; Essink-Bot, Marie-Louise

### VERSION 1 - REVIEW

<b>REVIEWER</b>	Peter Davis University of Auckland, New Zealand
<b>REVIEW RETURNED</b>	15-Jul-2015

<b>GENERAL COMMENTS</b>	<p>This is a very worthwhile topic and the methodological approach is appropriate and useful, but the objective is not defined as an objective in the abstract, the group is a lot narrower than seems (not just all ethnic minority, but first generation migrants/refugees without Dutch), the sample is small, incomplete and not well specified (what guided the purposive selection? not sure why a complete set of patients and providers not interviewed), not clear how and where triangulation (strictly defined) occurred, and there is not really a full set of data across all cases. The strength of the paper is in putting its finger on the role of the family and relations in empowering disadvantaged groups in a potentially high-risk setting, although the authors rightly point to the possible downsides to this. Where I felt the paper could have done more was to make the connection to the difficulty that mono-cultural institutions have in dealing with cultural diversity and difference. The emphasis should surely be on the failure of the institution rather than the agency of the patients. In New Zealand interpreters are often available, and we have had to change many assumptions to accommodate indigenous and other cultures, not always successfully.</p>
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<b>REVIEWER</b>	Nan Greenwood Reader, Faculty of Health, Social Care and Education Kingston University and St George's, University of London, United Kingdom
<b>REVIEW RETURNED</b>	17-Jul-2015

<b>GENERAL COMMENTS</b>	<p>The qualitative study explores an interesting and important area of patient safety and the role of families using data from several sources.</p> <p>There are some interesting findings but there are also several concerns with the manuscript as it stands.</p> <p>Firstly, as with much of the work investigating minority groups, the failure to have a 'majority' Dutch comparison group is a major</p>
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	<p>limitation. This makes it difficult to know when or if minority relatives are different to those from majority groups. I wondered if the reference to 'usual role' was intended to refer to this but this was not made clear. This term needs much greater explanation.</p> <p>Secondly, the grouping of all these diverse ethnic groups into 'ethnic minority' is clearly an oversimplification and needs both recognition and discussion. Such diverse cultural groups may have very different perceptions of their roles in supporting patients.</p> <p>The other main concern relates to the methods. Some discussion about the advantages and disadvantages of using different data sources would be beneficial. It was difficult to ascertain exactly how the different data sources were used and combined. How were the different data sources weighted and how were apparent discrepancies handled? How was the richness of the data determined when deciding that an interview was not needed? Also it is unclear how many potential interview participants were approached. The reference to 'reflection' also needs explanation. Overall this means that it would not be possible to reproduce the study.</p> <p>Some of the themes come across as insufficiently developed and rather descriptive. These need a bit more work</p> <p>For some of the statements, the evidence was unclear – e.g. on page 23 where it says that relatives often thought that their presence would enhance the recovery of the patient....'</p> <p>The Discussion also failed to unpick how families of minority groups are similar or different to those of majority groups. This meant that it was unclear from the discussion to whom 'relatives' referred to.</p> <p>There are other less significant issues that need to be sorted out. For example, the English needs improving and it was unclear why some text was italicised.</p> <p>Finally, it was also unclear why the last appendix was included.</p>
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<b>REVIEWER</b>	Judith Sim University of Edinburgh, Scotland, UK
<b>REVIEW RETURNED</b>	28-Jul-2015

<b>GENERAL COMMENTS</b>	<p>This is an interesting paper which takes as its focus an important issue. Being accompanied by relatives during the course of hospital stays is common (even normal) practice in some areas from which migrants come as suggested by a number of hospital ethnographies in addition to the references cited by the authors. It has also previously been noted as a source of conflict between hospital staff and minority ethnic/migrant patients and their relatives in wider literature on cultural competence. This suggests that it is an issue of significance beyond the Netherlands, but it has not in itself been the focus of much previous work, and neither has it previously been linked to patient safety.</p> <p>This paper brings different data sources to bear on exploring the role of relatives in supporting minority ethnic patients in hospitals in the Netherlands. My main comments on the paper (and reservations) relate to the nature of these methods and specifically how they are described, combined and how findings are derived from them. The methods are sound but I query how rigorously they have been</p>
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	<p>translated into practice in generating data.</p> <p><b>Methods and how they relate to findings</b></p> <p>In theory this is strong, and triangulation between data from patient notes, interviews with patients, their relatives and health staff and observation is claimed as a strength of the paper. However, there are a number of problems in relation to how the intended methodology translated into practice which limit the claims made for it. These should be more fully acknowledged:</p> <ul style="list-style-type: none"> <li>- In less than a quarter of cases (4/20) are relatives interviewed, and only two patients are interviewed. In the bulk of the cases data is derived from the patient records only. Fully triangulated data was only available for a very small minority of patients. The limited number of interviews and challenges of collecting such data in the context of non-Dutch speaking patients is acknowledged, but might this study be more accurately described as one based on patient records supplemented by some additional qualitative material</li> <li>- While material from patient records is claimed as rich – sufficiently so to stand on its own in a majority of cases – the nature of what is contained in the records is not made clear. How detailed were notes about the involvement of relatives? Was this consistent between hospital sites and different wards and clinics? Where the accounts of relatives and doctors and nurses and observational material were also available how did these compare with the material in the notes? Were there any potential differences between sources which suggested what might be filtered into and out of patient records? The perspectives of patients and professionals in relation to what is thought to have happened as well as how it is interpreted might be expected to be rather different from each other but this does not really emerge in the ‘findings’ section. This may be because no differences emerged – but if so, this should be made clear. In sum, the nature, strengths and limitations of patient records as a source of data could have been more fully described. Using one source of data to reflect on another would also have been fascinating – but is perhaps a different kind of study.</li> <li>- The patient records which are the primary data source common to all cases do not appear to feature largely as data in the ‘Findings’ section which rests primarily on evidence derived from interviews which made up a minority of the data collected o observation.</li> <li>- How long were periods of observation?</li> <li>- Mean interview times would be useful given the range of</li> </ul>
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	<p>lengths of interview – between 20 minutes and 2 hours for relatives and patients.</p> <ul style="list-style-type: none"> <li>- Greater precision is needed in relation to claims made about data saturation. Did this apply to the patient records which are the primary data source or also to interviews with relatives and observational material?</li> </ul> <p>Below are a number of points of detail:</p> <p>Abstract</p> <p>This is clear, although I am uncertain why (p2 Line 28) (relatives of) patients is put into brackets. In line 36 relatives are described as taking 'the role of the patient'. It may be clearer to phrase this as acting as proxies or substitutes for the patient</p> <p>Page 7, line 11: it is mentioned that some interviews with relatives took place on the patient's admission when the care which is the focus of the paper had presumably not yet taken place. I found this a little puzzling, but I may have misinterpreted the meaning intended here.</p> <p>Introduction</p> <p>Line 14 onwards. Problems are couched in terms of a deficit model – i.e. what the patient groups are lacking rather than the extent to which the health services are or are not sufficiently culturally competent to meet the needs of minority ethnic patients. It may be more in the spirit of what follows to phrase this in a more balanced way in terms of encounters between patients and health systems.</p> <p>Line 24: The population becoming more diverse should be referenced</p> <p>Discussion and conclusion</p> <p>The point about relatives potentially both constituting and deflecting risk is nicely drawn from the data, and re-frames the 'problem' from one of relatives interfering negatively with the care process to the importance of collaboration with relatives. This leads well into the practice implications of study findings</p> <p>The fact that some findings may equally apply to some within the general majority ethnic population is recognised and acknowledged. It may have been useful here to draw more thoroughly on more general literature on the role of relatives in supporting patients in hospital. Alternatively, a sample of people from the members of the majority ethnic Dutch population could have been drawn to act as a brake against assuming that findings are necessarily specific to minority ethnic people as described by Pfeffer (2004) in relation to breast screening. One example signalling a dispute about what is in the best interests of the patient used in the findings section - page 12 line 24 onwards – could almost certainly have occurred amongst majority ethnic people. Gender could also have been raised as a potential factor shaping findings given that twice as many male than</p>
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	female patients were sampled.  Pffefer, N. (2004) 'Screening for breast cancer: candidacy and compliance' <i>Social Science &amp; Medicine</i> 58: 151–160
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<b>REVIEWER</b>	Philip Clissett University of Nottingham England
<b>REVIEW RETURNED</b>	06-Aug-2015

<b>GENERAL COMMENTS</b>	<p>The authors are to be congratulated on completing a very clearly written paper reporting a piece of qualitative research that will add to our understanding of the interactions of patients, relatives and staff in acute hospital settings. I have made a number of comments as I went through the paper and these are listed below. While the ethics question is obviously important (point 3), I have two main concerns about this paper. Firstly, the study does not appear to be informed by any philosophical approach to qualitative research (by this I mean phenomenology, grounded theory, ethnography etc.). It would be useful to know about the principles which informed the study because this will have informed any decisions that were made during the conduct of the study. Secondly, unsurprisingly, many of the findings that you uncovered do not apply specifically to ethnic minority groups and I have read papers that report similar findings to yours. My other comments are as follows:</p> <ol style="list-style-type: none"> <li>1. Page 3, strengths of study – this is a qualitative study so results cannot be 'broadly generalizable'. Within qualitative research transferability is achieved by providing sufficient detail about the research setting and population to enable the reader of the paper make a judgement about transferring the findings into another specific setting.</li> <li>2. I think that this research study needs some philosophical underpinning. It is not clear which qualitative research paradigm has informed the approach to this study. This would be a useful inclusion in the paper.</li> <li>3. Ethical aspects (page 6) – it is unclear whether the interview element of the study was approved by the medical ethics committees. It states clearly that the umbrella study was covered but not the interview element.</li> <li>4. Page 7 – I think you need to find a different word to a 'case' to describe a hospital admission. To the English ear, the word case feels very impersonal.</li> <li>5. It is not clear why you chose 20 cases. Did you reach data saturation?</li> <li>6. Page 7, line 28 'Sometimes the data were so rich we did not plan an interview'. This is surprising as they might have been able to offer more insights.</li> <li>7. I assume that the table of quotations has the goal of ensuring the paper remains within the word limit. However, it does not really work. The reader wants to review the data to see if it is reflecting the point</li> </ol>
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	<p>made by the author. This is much more difficult to do when the data has been put into a table.</p> <p>8. While I understand that the reason for the focus on ethnic minority patients is that this is the group of people about whom the data were being collected but, with the exception of the role of 'interpreter' most of the findings could apply to most other types of patients and their visitors. It would be interesting in the discussion had this been explored more.</p>
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## VERSION 1 – AUTHOR RESPONSE

### Reviewer: 1

Reviewer Name Peter Davis

Institution and Country University of Auckland, New Zealand Please state any competing interests or state 'None declared': None declared

Comment	Reaction
This is a very worthwhile topic and the methodological approach is appropriate and useful, but the objective is not defined as an objective in the abstract,...	<p>The objective in the abstract is indeed not formulated as objective. We have changed the objective paragraph:</p> <p>P1 Relatives of ethnic minority patients often play an important role in the care process during hospitalisation. Our objective was to analyse the role of these relatives in relation to the safety of patients during hospital care.</p>
.... the group is a lot narrower than seems (not just all ethnic minority, but first generation migrants/refugees without Dutch).....	<p>Because we only included patients aged 45 or older (= inclusion criterion of umbrella study), almost all patients were 1<sup>st</sup> generation migrants, and hardly any any of them were refugees.</p> <p>In the paper describing the design of the umbrella study, we have extensively described the background of ethnic minorities in the Netherlands.</p> <p>We added a reference to the umbrella study in the methods section</p> <p>Assuming that the reviewer means 'without Dutch proficiency': Not all patients in this sample were non-Dutch speaking. On page 7, in the 'cases' paragraph, we state that patients had different levels of Dutch proficiency. We have clarified this a little bit more.(p7)</p> <p>P7 ...and different levels of Dutch language proficiency, <u>varying from adequate Dutch proficiency to no Dutch proficiency at all.</u></p>
..., the sample is small, incomplete and not well specified (what guided the purposive selection? not sure why a complete set of patients and providers not interviewed),...	<p>In qualitative research it is not possible to quantify an adequate sample size. For the goal of our study (i.e. to explore the role of relatives in relation to patient safety of admitted patients), we considered our sample sufficiently large because data were saturated.</p> <p>The selection was in the first place guided by compiling a heterogeneous sample, and in the second place by finding contra-examples (p 6). When record data were considered rich enough (See also reviewers 2-4) we did not plan an interview. Unfortunately, also few patients and careproviders were not reached for an interview. (Table 1)</p>

	We have specified when we considered record data 'rich enough' (P6, see table reviewer 2)
... not clear how and where triangulation (strictly defined) occurred,...	<p>Denzin identifies 4 types triangulation; data triangulation, investigator triangulation, method triangulation and theory triangulation (Denzin, 1989). We used method triangulation. Method triangulation involves the use of multiple methods of data collection about the same phenomenon. The aim of triangulation is to overcome the intrinsic bias that may come from using single methods to study a phenomenon. Multiple data collection methods can increase the possibility that an internally consistent picture of the phenomenon emerges.</p> <p>Denzin, N. K. (1989). The research act (3rd ed.). Englewood Cliffs, NJ: Prentice Hall</p> <p>We have also added this to the methods section (p 5)</p>
... and there is not really a full set of data across all cases....	See comment before: We justified why we did not plan interviews for all cases.
The strength of the paper is in putting its finger on the role of the family and relations in empowering disadvantaged groups in a potentially high-risk setting, although the authors rightly point to the possible downsides to this. Where I felt the paper could have done more was to make the connection to the difficulty that mono-cultural institutions have in dealing with cultural diversity and difference. The emphasis should surely be on the failure of the institution rather than the agency of the patients. In New Zealand interpreters are often available, and we have had to change many assumptions to accommodate indigenous and other cultures, not always successfully.	<p>We agree that we could have paid more attention in this paper to the fact that a hospital admission is a potential high-risk situation for ethnic minority patients because of a lack of cultural competent care in general. In the meanwhile we have published our results of a large record review study comparing AEs between Dutch and ethnic minority patients showing that ethnic minorities are not at increased risk for AEs. One of our hypothesized explanation of these results is that relatives, who we observed to be around more often in admissions of ethnic minority patients, could have played a protective role. We have added this both in the introduction (p4) and discussion sections (p14)</p> <p>Van Rosse F, Essink-Bot ML, Stronks K, de Bruijne MC, Wagner C. Ethnic minority patients not at increased risk of adverse events during hospitalization in urban hospitals in the Netherlands: results of a prospective observational study. BMJ Open. 2014 Dec 30;4(12):e005527</p>



Reviewer: 2

Reviewer Name Nan Greenwood

Institution and Country Reader,

Faculty of Health, Social Care and Education Kingston University and St George's, University of London, United Kingdom

Please state any competing interests or state 'None declared': None

The qualitative study explores an interesting and important area of patient safety and the role of families using data from several sources.

There are some interesting findings but there are also several concerns with the manuscript as it stands.

Comment	Reaction
Firstly, as with much of the work investigating minority groups, the failure to have a 'majority' Dutch comparison group is a major limitation. This makes it difficult to know when or if minority relatives are different to those from majority groups. I wondered if the reference to 'usual role' was intended to refer to this but this was not made clear. This term needs much greater explanation.	<p>"The usual role of visitor" was not meant to describe the 'majority Dutch' population. We described this role on page 10 in the results section.</p> <p>All relatives, irrespective of their background, can act in this role. At the same time, Dutch relatives can take the other roles we described in this paper. (Only the role of interpreter will not often be taken). We describe this on page 15 of the discussion section.</p> <p>We clarified that this role did not interfere with the care process , and that this role was interpreted differently by different visitors, irrespective of their ethnic background. (p 10)</p> <p>A sub-sample of Dutch cases would indeed have enriched the study, but –in our opinion- without we have also managed to make an interesting start in this quite new subject of research.</p>
Secondly, the grouping of all these diverse ethnic groups into 'ethnic minority' is clearly an oversimplification and needs both recognition and discussion. Such diverse cultural groups may have very different perceptions of their roles in supporting patients.	<p>It is true that different groups have different perceptions of their roles in supporting patients. It was not our intention to 'oversimplify' this.</p> <p>We strived to include a heterogeneous sample <i>because</i> of diversity among different ethnic groups. Moreover, the risks that ethnic minorities face during hospital admission, are not all culturally funded.</p> <p>However, we agree that this needs discussion. We have added this to our discussion section. (p 17)</p>
The other main concern relates to the methods. Some discussion about the advantages and disadvantages of using different data sources would be beneficial. It was difficult to ascertain exactly how the different data sources were used and combined. How were the different data sources weighted and how were apparent discrepancies handled? How was the richness of the data determined when deciding that an interview was not needed? Also it is unclear how many potential interview participants were approached. The reference to 'reflection'	<p>In both the methods and discussion section we have named advantages (triangulation) and disadvantages (not all cases are complete, we have added this following the advice of another reviewer).</p> <p>About the weighting &amp; discrepancies: When data in records were not rich, interview data automatically weighted more. There were hardly any discrepancies between data sources. The only discrepancies we found were the care providers' perception and attitude towards relatives. These were well described we think.</p> <p>We agree that we could have specified the richness of record data a lot more. We have added text on this on page 6 (Also following the advice of another reviewer)</p> <p>In table 1 we specified all people that were approached (In italics the ones that did not participate – we have clarified this now in the legenda)</p> <p>Finally the clarification of 'reflection':</p>



also needs explanation. Overall this means that it would not be possible to reproduce the study.	We agree that 'reflection' was maybe not the right word to describe what we did. We have edited this paragraph and also clarified our 'interrater reliability' application and the goal to reduce bias.
Some of the themes come across as insufficiently developed and rather descriptive. These need a bit more work For some of the statements, the evidence was unclear – e.g. on page 23 where it says that relatives often thought that their presence would enhance the recovery of the patient....'	<p>We have followed the advice of reviewer 4 by putting the quotes back on the places where they originally were instead of putting them together in a table. This deepens the themes.</p> <p>Relatives often think their presence enhances recovery because of the roles they act. (Interpreter, caregiver). In many examples we underline this.</p>
The Discussion also failed to unpick how families of minority groups are similar or different to those of majority groups. This meant that it was unclear from the discussion to whom 'relatives' referred to.	<p>We are a bit puzzled by this comment and are not sure what the reviewer means. We try to answer the question the way we have interpreted it:</p> <p>Firstly, in the context of our study, it is not highly relevant who these relatives were. The point is that relatives can take different roles and that these roles can both increase and decrease the patient safety risk for a patient. It does not matter whether this relative is a sister of a neighbor.</p> <p>As we write in our introduction section, relatives are –obviously–, most of the time family members. And this does not differ between ethnic groups.</p>
There are other less significant issues that need to be sorted out. For example, the English needs improving and it was unclear why some text was italicised. Finally, it was also unclear why the last appendix was included.	<p>The manuscript was linguistically edited by a qualified translator (Who is also native in English) before submission.</p> <p>We have clarified the italicized text in table 1. (Those were the interview non-responses)</p> <p>We assume that you mean the appendix with Quotations in Dutch. This appendix is for Dutch readers as quotations in Dutch are even more descriptive than in English.</p>

Reviewer: 3

Reviewer Name Judith Sim

Institution and Country University of Edinburgh, Scotland, UK Please state any competing interests or state 'None declared': None declared

Please leave your comments for the authors below

This is an interesting paper which takes as its focus an important issue. Being accompanied by relatives during the course of hospital stays is common (even normal) practice in some areas from which migrants come as suggested by a number of hospital ethnographies in addition to the references cited by the authors. It has also previously been noted as a source of conflict between hospital staff and minority ethnic/migrant patients and their relatives in wider literature on cultural competence. This suggests that it is an issue of significance beyond the Netherlands, but it has not in itself been the focus of much previous work, and neither has it previously been linked to patient safety.

This paper brings different data sources to bear on exploring the role of relatives in supporting minority ethnic patients in hospitals in the Netherlands. My main comments on the paper (and

reservations) relate to the nature of these methods and specifically how they are described, combined and how findings are derived from them. The methods are sound but I query how rigorously they have been translated into practice in generating data.

Methods and how they relate to findings

In theory this is strong, and triangulation between data from patient notes, interviews with patients, their relatives and health staff and observation is claimed as a strength of the paper. However, there are a number of problems in relation to how the intended methodology translated into practice which limit the claims made for it. These should be more fully acknowledged:

Comment	Reaction
In less than a quarter of cases (4/20) are relatives interviewed, and only two patients are interviewed. In the bulk of the cases data is derived from the patient records only. Fully triangulated data was only available for a very small minority of patients. The limited number of interviews and challenges of collecting such data in the context of non-Dutch speaking patients is acknowledged, but might this study be more accurately described as one based on patient records supplemented by some additional qualitative material	<p>We agree that fully triangulated data was not available for the whole dataset, and we should endorse this in the discussion section.</p> <p>P15 The major strength of the present study is the use of different data sources, allowing for triangulation. Although fully triangulated data was not available for all cases, the different data sources strengthen the internal validity of the results.[Denzin 1989]</p> <p>We did edit the abstract a little bit to say that 8 of 20 record review data were added with interview data. By describing the record data more extensively and explaining that we only collected additional interview data when we considered the record data not rich enough, we already put more focus on the record data. Nonetheless, we want to keep the 'mixed methods' in the title of our paper.</p>
While material from patient records is claimed as rich – sufficiently so to stand on its own in a majority of cases – the nature of what is contained in the records is not made clear. How detailed were notes about the involvement of relatives? Was this consistent between hospital sites and different wards and clinics? Where the accounts of relatives and doctors and nurses and observational material were also available how did these compare with the material in the notes? Were there any potential differences between sources which suggested what might be filtered into and out of patient records? The perspectives of patients and professionals in relation to what is thought to have happened as well as how it is interpreted might be expected to be rather different from each other but this does not really emerge in	<p>We have clarified 'richness' of record data, as we indeed insufficiently did this in the paper so far. (See also comments of other reviewers) P6 (See reviewer 2)</p> <p>The material in the notes in the nursing records and the interview material did compare very well. That is one of the reasons that in case of a rich patient record, additional interview data were not always considered necessary.</p> <p>We agree that strengths and limitations of our main data source could have been more fully described. Strengths of record data are:</p> <ul style="list-style-type: none"> <li>- They are almost 'real time data' as the notes are most of the time made immediately after the patient contact and at least the same day</li> <li>- Especially in case of nursing records they are also longitudinal data: they follow the patient admission from the beginning to the end.</li> </ul> <p>Limitations are:</p> <ul style="list-style-type: none"> <li>- Notes are sometimes short (although not always!)</li> <li>- And therefore thoughts and considerations are not always written down.</li> </ul> <p>We have put some more attention on this in the discussion section.(p17)</p> <p>As we have now added on p6, when record review data were not rich enough because they were too short and there was a lack of considerations and thoughts, we tried to plan an interview.</p>

the 'findings' section. This may be because no differences emerged – but if so, this should be made clear. In sum, the nature, strengths and limitations of patient records as a source of data could have been more fully described. Using one source of data to reflect on another would also have been fascinating – but is perhaps a different kind of study.	
The patient records which are the primary data source common to all cases do not appear to feature largely as data in the 'Findings' section which rests primarily on evidence derived from interviews which made up a minority of the data collected o observation.	<p>The quotes and examples we chose to underline our results were indeed mostly from interviews. Only 3 out of 16 quotes originated from the record texts. We did not notice this ourselves!</p> <p>We have added two more quotes from patient records:</p> <ul style="list-style-type: none"> <li>- Q9 (p 12)</li> <li>- Q18 (p14)</li> </ul>
How long were periods of observation?	<p>For the umbrella study, the researcher spent at least ten hours a week on the wards where patient inclusion took place. (mid 2011-mid2013). This was where the family-involvement research plan was 'born'.</p> <p>Observation times of specific cases included in this study (e.g. outpatient visit observation, observation during patient inclusion, were added to table 1 (p 9)</p>
Mean interview times would be useful given the range of lengths of interview – between 20 minutes and 2 hours for relatives and patients.	All specific interview times were added to table 1 on page 9.
Greater precision is needed in relation to claims made about data saturation. Did this apply to the patient records which are the primary data source or also to interviews with relatives and observational material?	Data saturation applied in general. (See also pints above)

Below are a number of points of detail:

Comment	Reaction
<p><b>Abstract</b></p> <p>This is clear, although I am uncertain why (p2 Line 28) (relatives of) patients is put into brackets. In line 36 relatives are described as taking 'the role of the patient'. It may be clearer to phrase this as acting as proxies or substitutes for the patient</p> <p>Page 7, line 11: it is mentioned that some interviews with relatives took place on the patient's admission when the care which is the focus of the paper had</p>	<p>We agree with the reviewer that the abstract could be clarified at some points:</p> <p>Line 28: Changed into: with patients <u>and/or their</u> relatives</p> <p>Line 36: Changed into: the role of <u>substitutes of</u> the patient</p> <p>Regarding page 7, line 11: This in fact happened once, and was just before the patient was discharged.</p>

<p>presumably not yet taken place. I found this a little puzzling, but I may have misinterpreted the meaning intended here.</p>	
<p>Introduction Line 14 onwards. Problems are couched in terms of a deficit model – i.e. what the patient groups are lacking rather than the extent to which the health services are or are not sufficiently culturally competent to meet the needs of minority ethnic patients. It may be more in the spirit of what follows to phrase this in a more balanced way in terms of encounters between patients and health systems.</p>	<p>See also the last comment of reviewer 1.</p> <p>We agree that we could have paid more attention in this paper to the fact that a hospital admission is a potential high-risk situation for ethnic minority patients because of a lack of cultural competent care in general. Also, we have published a conceptual model in the design paper of the umbrella study.</p>
<p>Line 24: The population becoming more diverse should be referenced Discussion and conclusion The point about relatives potentially both constituting and deflecting risk is nicely drawn from the data, and re-frames the ‘problem’ from one of relatives interfering negatively with the care process to the importance of collaboration with relatives. This leads well into the practice implications of study findings The fact that some findings may equally apply to some within the general majority ethnic population is recognised and acknowledged. It may have been useful here to draw more thoroughly on more general literature on the role of relatives in supporting patients in hospital. Alternatively, a sample of people from the members of the majority ethnic Dutch population could have been drawn to act as a brake against assuming that findings are necessarily specific to minority ethnic people as described by Pfeffer (2004) in relation to breast screening. One example signalling a dispute about what is in the best interests of the patient used in the findings section - page 12 line 24 onwards – could almost certainly have occurred amongst majority ethnic people. Gender could also have been raised as a potential factor shaping findings given that twice as many male than female patients were sampled. Pfeffer, N. (2004) ‘Screening for breast cancer: candidacy and compliance’ <i>Social Science &amp; Medicine</i> 58: 151–160</p>	<p>We have referenced our statement that the population is becoming more diverse:</p> <p>Stoeldraijer L, Garssen J: Prognose van de bevolking naar herkomst, 2010-2060 [in Dutch] [Population forecast by ethnic background 2010-2060]. <i>Bevolkingstrends</i> [Population trends] 2011., 59 <a href="http://www.cbs.nl/nr/rdonlyres/476f84a8-b876-43b4-aa21-350338c052eb/0/2011k1b15pub.pdf">http://www.cbs.nl/nr/rdonlyres/476f84a8-b876-43b4-aa21-350338c052eb/0/2011k1b15pub.pdf</a> website</p> <p>Regarding your point that it may have been useful here to draw more thoroughly on more general literature on the role of relatives in supporting patients in hospital: We really wanted to focus on the relation between relatives and patient safety and not broadly describe the role of relatives in general, as there is so much literature, especially in pediatrics and intensive care.</p> <p>And indeed, a sample of Dutch patients could have acted as a brake against assuming that findings are necessarily specific to ethnic minorities. This would have strengthened our design even more, and therefore we have included a large sample of Dutch patients in the umbrella study. (See also comment 1 of reviewer 2), We did not know the example of Pfeffer and colleagues and by reading the following part in the discussion: ‘The findings reported here demonstrate the value of including white respondents in social research which operationalises ethnicity. Their presence has minimized the risk of jumping to unwarranted, simplistic conclusions about the beliefs and behaviours of black and minority ethnic women; it has also allowed general themes to emerge which suggest new approaches to thinking about all women’s understanding of their risk of breast cancer and the reasons why they comply with or refuse their invitation to attend for mammography screening.’ ...We agree that we should add to our discussion section that not including a Dutch sample is a possible limitation. (p 16, paragraph “generalizability to the majority population”)</p>



Reviewer: 4

Reviewer Name Philip Clissett

Institution and Country University of Nottingham England Please state any competing interests or state 'None declared': None declared

Please leave your comments for the authors below The authors are to be congratulated on completing a very clearly written paper reporting a piece of qualitative research that will add to our understanding of the interactions of patients, relatives and staff in acute hospital settings. I have made a number of comments as I went through the paper and these are listed below. While the ethics question is obviously important (point 3), I have two main concerns about this paper.

Comment	Reaction
Firstly, the study does not appear to be informed by any philosophical approach to qualitative research (by this I mean phenomenology, grounded theory, ethnography etc.). It would be useful to know about the principles which informed the study because this will have informed any decisions that were made during the conduct of the study.	Our study was informed by the empiric-analytical tradition (Guba and Lincoln 2005) in which reality is assumed to exist and can be known and analysed in terms of categories and diagrams (Miles and Huberman 2014). Miles and Huberman (1994) suggest that qualitative data analysis consists of different procedures, including data reduction which refers to the process whereby the transcripts, field notes, observations, are reduced and organised, and by the process of coding, in which codes preferably are displayed in the form of matrices in order to facilitate the analysis of themes. (Added in 'data analysis' section, p 8)  Guba EG, Lincoln YS. Paradigmatic controversies, contradictions, and emerging confluences. In: NK Denzin & YS Lincoln (Eds). The Sage Handbook of Qualitative Research (3rd edition) (pp 191-216). Thousand Oaks: Sage, 2015.  Miles MB, Huberman, Huberman M. Qualitative Data analysis. An expended resource book. 3rd edition. Thousand Oaks: Sage, 2014.
Secondly, unsurprisingly, many of the findings that you uncovered do not apply specifically to ethnic minority groups and I have read papers that report similar findings to yours.	Yes, we fully agree, and we have described this in the 'generalisability section in our discussion
1. Page 3, strengths of study – this is a qualitative study so results cannot be 'broadly generalizable'. Within qualitative research transferability is achieved by providing sufficient detail about the research setting and population to enable the reader of the paper make a judgement about transferring the findings into another specific setting.	We fully agree
2. I think that this research study needs some philosophical under-pinning. It is not clear which qualitative research paradigm has informed the approach to this study. This would be a useful inclusion in the paper.	See the reaction in the 1 <sup>st</sup> row of this table above.



3. Ethical aspects (page 6) – it is unclear whether the interview element of the study was approved by the medical ethics committees. It states clearly that the umbrella study was covered but not the interview element.	According to the Dutch Medical Research Involving Human Subjects Act, this study did not require medical-ethical approval, as was confirmed in writing by the medical ethical committee of the AMC. We followed the ethical principles for medical research involving human subjects as laid down in the Declaration of Helsinki and adopted by the World Medical Association (WMA Declaration of Helsinki, 2000), taking every precaution to ensure patient and provider confidentiality. Also, the researcher passed the good clinical practice exam.
4. Page 7 – I think you need to find a different word to a 'case' to describe a hospital admission. To the English ear, the word case feels very impersonal.	It took us a long time to find a 'covering' word for 'hospital admission of an ethnic minority patient'. And although we agree that 'case' sounds a bit impersonal, we did not change this because all other options did not cover. However, we have used the word 'case' only in the methods (=technical) section, and not in the results section where we always described the patient admission more personally.
5. It is not clear why you chose 20 cases. Did you reach data saturation?	We have described the selection of cases and data saturation in the methods section (p6/7), and also discussed data saturation a little bit more in the discussion section on page 16 (In yellow the bits that were added). See also comments of other reviewers.
6. Page 7, line 28 'Sometimes the data were so rich we did not plan an interview'. This is surprising as they might have been able to offer more insights.	We have clarified 'richness' of record data, as we indeed insufficiently did this in the paper so far. (p6) (See also comments of other reviewers)
7. I assume that the table of quotations has the goal of ensuring the paper remains within the word limit. However, it does not really work. The reader wants to review the data to see if it is reflecting the point made by the author. This is much more difficult to do when the data has been put into a table.	We fully agree and have put all quotations back 'on their original spots'
8. While I understand that the reason for the focus on ethnic minority patients is that this is the group of people about whom the data were being collected but, with the exception of the role of 'interpreter' most of the findings could apply to most other types of patients and their visitors. It would be interesting in the discussion had this been explored more.	(See also comments of other reviewers. ) On p 16 of the discussion section we describe this issue. We have also added the potential limitation of not including a Dutch sample.

